(Facility Name)

TRIAL BALANCE OF COSTS

(Date)

Description	A Trial Balance Costs	B Medicaid Cost Adjustments	C Adjusted Medicaid Costs	D Cost Per Day
PRIMARY PATIENT CARE COSTS				
1. Nursing Staff Salaries				
2. Nursing Staff Benefits				
3. Nursing Staff Training				
4. Other				
5. Subtotal				
SECONDARY PATIENT CARE COSTS				
6. Clinical Consultants				
7. Social Services				
8. Employee Benefits				
9. Raw Food				
10. Medical Supplies				
11. Pharmacy (non Rx)				
12. Other				
13.				
14. Subtotal				
SUPPORT SERVICE COSTS				
15. Dietary				
16. Operation and Maintenance of Facility				
17. Housekeeping				
18. Laundry and linen				
19. Patient Recreation				
20. Employee Benefits				
21. Other				
22. Subtotal				
ADMINISTRATIVE AND ROUTINE COSTS				
23. Owner/Executive Director Salary				
24. Medical and Nursing Director Salary				
25. Other Administrative Salaries				
26. Employee Benefits				
27. Medical Records				
28. Training				
29. Interest-Working capital				

TN SP 248 Approval date 9/1/87

Supercedes TN SP 227 Effective date 7/1/87

(Facility Name)

TRIAL BALANCE OF COSTS

(Date)

Description	A Trial Balance Costs	B Medicaid Cost Adjustments	C Adjusted Medicaid Costs	D Cost Per Day
30. Home Office-Admin.				
31. Other				
32. Subtotal				
CAPITAL COSTS				
33. Lease Costs				
34. Interest - Mortgage				
35. Property Taxes				
36. Depreciation				
37. Home Office - Capital				
38. Other				
39. Subtotal				
40. SUBTOTAL				
ANCILLARY COSTS				
41. Laboratory				
42. X-Ray				
43. Physical Therapy				
44. Occupational Therapy				
45. Speech Therapy				
46. Pharmacy (Rx)				
47. Oxygen				
48. Other				
49. Subtotal				
OTHER COSTS				
50. Gift, Beauty Shop, etc.				
51. Util. Review				
52. Subtotal				
53. TOTAL COSTS				

FOR MEDICAID USE ONLY

	Cost per Day	DE Class Rate	Adjustments	Final Cost per Day
Primary Patient Care Costs				
Secondary Patient Care Costs				
Support Service Costs				
Administrative & Routine Costs				
Capital Costs				
TOTALS				

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_____

(Facility Name)

ADJUSTMENTS TO COST

_____

(Date)

Adjustment No.	Adjustment For:	Basis A. Cost B. Revenue	Amount	Expense Offset	Page No.	Line No.
1	Advertising	A	$_____	Administrative-Other	3	31
2.	Bad Debt Expense	A	_____	Administrative-Other	3	31
3.	Cafeteria Guest Meals	B	_____	Dietary	2	15
4.	Contributions	A	_____	Administrative-Other	3	31
5.	Depreciation	A	_____	Depreciation	3	36
6.	Fund Raising Expense	A	_____	Administrative-Other	3	31
7.	Home Office-Admin.	A	_____	Home Office-Admin.	3	30
8.	Home Office-Capital	A	_____	Home Office-Capital	3	37
9.	Interest Paid to Related Parties-Admin.	A	_____	Int.-Working Capital	2	29
10.	Interest Paid to Related Parties-Capital	A	_____	Interest-Mortgage	3	34
11.	Invest. Income-Admin.	B	_____	Int.-Working Mortgage	2	29
12.	Invest. Income-Capital	B	_____	Interest-Capital	3	34
13.	Laundry & Dry Cleaning	B	_____	Laundry & Linen	2	18
14.	Misc. Income	B	_____	Administrative-Other	3	31
15.	Owner/Executive Director Salary (Excess)	A	_____	Owner/Exec. Director Salary (Excess)	2	23
16.	Purchase Discounts	B	_____	Administrative-Other	3	31
17.	Rental Income	B	_____	Lease Costs	3	33
18.	Sale of Medical Supplies	B	_____	Medical supplies	2	10
19.	Sale of Drugs	B	_____	Pharmacy (non Rx)	2	11
20.	Taxes on Income (Local, State & Federal)	A	_____	Administrative-Other	3	31
21.	Telephone Revenues	B	_____	Administrative-Other	3	31
22.	Television Revenues	B	_____	Capital Cost-Other	3	38
23.	Vending Machines	B	_____	Capital Cost-Other	3	38

OTHER ADJUSTMENTS

24. _____ _____
25. _____ _____
26. _____ _____
27. _____ _____
28. _____ _____
29. _____ _____
30. _____ _____
31. _____ _____
32. _____ _____
33. _____ _____
34. _____ _____
35. _____ _____

SP 248 Approval Date 9/1/87
Supercedes TN SP 227 Effective date 7/1/87

EXPLANATION OF ADJUSTMENTS

Adjustment Number	Explanation

SI 248 Approval Date 9/2/87

Supersedes TI 8227 Effective Date 7/1/87

PATIENT DAYS

BEDS AVAILABLE

1. Beginning of Period _____

2. Beds added (removed) during Period _____

   Date(s) added (removed): _____

3. End of Period (Line 1 +/- 2) _____

4. TOTAL BED DAYS AVAILABLE _____

5.

	Patient Days By Patient Class					
Revenue Source	A	B	C	D	E	TOTAL
A. Medicaid						
B. Medicare						
C. Private Pay						
D. Other						
E. Total						

6. PERCENTAGE OCCUPANCY (Round to four places: xx.xx%) _____
   (Line 5E Total - Line 4)

7.

	Admissions	Discharges	Deaths
A. Medicaid			
B. Medicare			
C. Private Pay			
D. Other			
E. Total			

SP 248 Approved 9/2/87

HB 8227 Effective 7/1/87

(Facility Name)

STATEMENT OF OPERATIONS

(Date)

LINE #		
1.	TOTAL PATIENT REVENUE	$
2.	OPERATING EXPENSES	
3.	INCOME FROM OPERATIONS (Line 1 - 2)	
4.	OTHER INCOME	
5.	OTHER EXPENSES	
6.	INCOME (LOSS) BEFORE TAXES (Lines 3 + 4 - 5)	
7.	INCOME TAXES	
8.	NET INCOME (LOSS) (Line 6 - 7)	
		$

SP 248 Approval date 9/2/87

IN SP227 Effective date 7/1/87

(Facility Name)

STATEMENT OF REVENUE

(Date)

PATIENT REVENUE	
ROUTINE CARE	$
1. Medicaid	
2. Medicare	
3. Blue Cross	
4. Private Pay	
5. Other	
6. TOTAL ROUTINE CARE	
7. DRUGS	
8. LABORATORY CHARGES	
9. X-RAY	
10. PHYSICAL THERAPY	
11. OCCUPATIONAL THERAPY	
12. OTHER	
13. TOTAL PATIENT REVENUE	
OTHER SOURCES OF REVENUE	
14. Gifts, Grants and Awards	
15. Investment Income (other than interest)	
16. Interest Income	
17. Rental	
18. Purchase Discounts	
19. Telephone and Television Charges	
20. Rebates and Refunds	
21. Laundry and Dry Cleaning	
22. Cafeteria Guest Meals	
23. Vending Machines	
24. Sale of Goods and Services to other than Patients	
25. Other	
26. TOTAL OTHER REVENUE	
27. TOTAL ALL SOURCES OR REVENUE	$

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Supercedes TN SP 22J Effective date 7/1/87

ADDITIONAL INFORMATION

1. Have all items which were the subject of a previous audit adjustment been properly accounted for in this report? _____

2. If this statement is prepared by an outside party, are you aware of all prior audit adjustments, if any, made by the Medicaid Agency for this facility? If not, you should familiarize yourself with such adjustments and the basis upon which they were made. _____

3. Did this facility, during the cost reporting period, purchase or lease any items from a related party (as defined in regulation 405.427)? _____

4. Has ownership of this facility changed since the last statement was filed? If yes, please attach schedule of changes. _____

5. This statement is prepared on the same basis as:
   (check one only)
   1. Financial Statements _____
   2. Tax Returns _____
   3. Other: (describe) _____

6. Indicate how depreciation for book purposes is calculated:

7. List all of your facility's charges per private patient day. Specify by type of charge, e.g., skilled care charge, private and semi-private room rate, etc. _____

_____

_____

9. Does the facility have vehicles used for patient transportation for medical services? If yes, please describe and indicate total costs included on pages 2 and 3. _____

10. Are all routine expense items allocated to cost centers in accordance with the instructions? Yes ( ) No ( )

    If not, provide the following information for those items which are allocated differently. Use an additional sheet if necessary.

Expense Item Name	Report Cost Center	Correct Cost Center (per Instructions)	Estimated Amount of Expense Item	Estimation Method

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11. OWNERS/EXECUTIVE DIRECTOR COMPENSATION

Name	% Stock Owned	Salary	Benefits	Other	Average Hours Per Week

Descriptions of each person's normal duties:

12. RELATED PARTY TRANSACTIONS

Name	Relationship	Amounts Paid	Amounts Due to/from	Description

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GENERAL INSTRUCTIONS

I BASIS OF REIMBURSEMENT

A. Payment is made for skilled nursing and intermediate care facility services on a reasonable cost-related basis. Reasonable cost is determined according to Medicare principles and is subject to state audit and adjustment.

B. Effective for fiscal years beginning after October 1, 1987, the State has established a new basis of cost reimbursement with prospective rates for three classes of facilities: (1) State operated nursing homes; (2) State operated specialized institutions; and (3) private facilities. Prospective rates for both types of State operated facilities and private facilities are determined based on an analysis of five separate cost centers. (See Medicaid State Plan for specific details on the cost reimbursement methodology.) These rates, for all State and private facilities, include an inflation factor and are not subject to retroactive revision, except for adjustments due to non-allowable costs included in prior years.

II REPORTING REQUIREMENTS

A. A Statement of Reimbursement Cost for Skilled and Intermediate Care Nursing Facilities Title XIX is required to be filed by all providers of services under Title XIX.

B. A complete and accurate report should be submitted to the Medicaid Agency by September 30th.

C. Extensions may be requested by submitting, in writing, to the Medicaid Agency, an explanation why an extension is needed. Extensions may be granted for a thirty day period of time.

D. Failure to submit timely reports, when the facility has not been granted an extension by the Medicaid Agency, will cause the following:

1. For the first thirty days that the report is late, 20% of the facility's payments will be withheld until report is submitted.

2. If the report is 31 to 60 days late, all payments will be suspended until the report is received. Payments will be reinstated retroactive to October 1st.

3. If the report is not received by November 30th, no rate increase will be given to the facility for that year and payments continue suspended until the report is received.

III RECORDS

A. The Statement of Reimbursement Cost for Skilled and Intermediate Care Nursing Facilities Title XIX should be prepared from the books and records of each facility on the same basis as its financial statements are prepared. If no financial statements are prepared, the Statement of Reimbursement Cost for Skilled and Intermediate Care Nursing Facilities Title XIX should be prepared on the same basis as the tax return for the facility is prepared.